CompPartners Final Report

CompPartners Peer Review Network
Physician Review Recommendation
Prepared for TDI/DWC

Claimant Name: ___
Texas IRO #: ___
MDR #: M2-06-0178-01
Social Security #: ___
Treating Provider: Elisa Garza-Sanchez, M.D.
Review: Chart
State: TX

Review Data:

- **Notification of IRO Assignment dated 10/21/05, 1 page.**
- **Receipt of Medical Dispute Resolution Request dated 10/21/05, 1 page.**
- **Medical Dispute Resolution Request/Response dated 10/4/05, 1 page.**
- **Provider Federal Tax Identification Number and the License/Certification/Registration Number Request Form, 1 page.**
- **Table of Disputed Services Form dated, 1 page.**
- **Medical Records Review dated 2/8/05, 7 pages.**
- **Chronic Pain Management Evaluation Report dated 8/17/05, 10 pages.**
- **Review Determination Report dated 9/19/05, 2 pages.**
- **Fax Cover Sheet dated 9/22/05, 1 page.**
- **Review Determination Report dated 9/30/05, 2 pages.**
- **Fax Cover Sheet /Reconsideration Request dated 9/13/05, 9 pages.**

Reason for Assignment by TDI/DWC: Determine the appropriateness of the previously denied chronic pain management, three sessions a week for 7 weeks, for 20 sessions..

Determination: UPHELD - previously denied chronic pain management, three sessions a week for 7 weeks, for 20 sessions.

Rationale:
Patient's age: 57 years.
Gender: Male.
Date of Injury: ___
Mechanism of Injury: Not stated for this review.
Diagnosis: Low back pain.

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The injured worker sustained injuries to his low back secondary to a slip and fall on an oil-spilled floor. The patient landed on his buttocks and left side, causing him to have pain in his low back and left leg. The patient was advised to see the company doctor who returned him to light duty. The patient continued with the above symptoms, and sought treatment from Dr. Ortegon, who continued him under light duty service and referred him for a lumbar MRI without contrast, which was performed on February 15, 2002. This report revealed at the L3-4 level, a small rent in the annulus fibrosis posteriorly. At the L4-L5 level, broad-based posterior bulging 3 to 4 mm in anterior/posterior diameter. Also, there was degenerative facet arthritis with moderate central bilateral spinal stenosis. At the L5-S1 level, there was posterior bulging/protrusion measuring 3 mm in anterior/posterior diameter with associated degenerative facet arthritis. Due to the above continued pain complaints, the patient went to Dr. Chowdhury, who diagnosed this patient with lumbar spondylosis with L4-5 and L5-S1 facet arthropathy. The patient subsequently underwent a radiofrequency intervention of the lumbar facet joints at the left L2-3, L3-4, L4-5, and L5-S1, on June 12, 2003.

On August 27, 2003, the patient underwent a second lumbar MRI without contrast. This showed L4-5 mild disk bulge at the L5-S1 level, with disk herniation measuring approximately 2 mm, and early degenerative disk disease. On February 11, 2004, the patient was placed in a work hardening program for six weeks at Rehab Institute of South Texas and demonstrated the ability to perform at the light physical demand level. Due to continued low back complaints and a VAS score of 5 out of 10 with radiation into the lower extremities bilaterally, left greater than right and associated tingling sensations, the patient underwent an orthopedic surgery evaluation on June 17, 2004. At that time, the patient had been taking Celebrex, Skelaxin, Tizanidine, and Zoloft. Physical examination revealed restricted range of motion to flexion and extension and right and left lateral bending. The working diagnoses involved multilevel lumbar disk protrusions at L3-4 to L5-S1, facet arthritis L4-5 to L5-S1, and anxiety/stress/depression due to chronic pain behavior. There was no mention of treatment options at that time. Due to continued worsening of lumbar radiculopathy, the patient was referred to a second pain management specialist, Dr. Donald Kramer. Dr. Kramer recommended another repeat lumbar MRI, as well as bilateral medial branch nerve blocks to the lumbar facets at L3-4 to L5-S1. This procedure was denied. By January 20, 2004, the patient's medications were no longer being approved, according to Dr. Sanchez' pain assessment note dated November 8, 2004. Plan of care at that time, included continuation of home exercises, hot packs to the lumbar spine, and samples of Celebrex 200 mg b.i.d., and Flexeril 5 mg t.i.d.

On April 14, 2005, the patient continued to experience low back pain, and a series of three injections to the lumbar spine, performed by Dr. Kramer, had not helped at all. The last note from Dr. Perez, orthopedic surgeon, on August 17, 2005, revealed worsening of the low back and lower extremity pain with a plan of treatment to include continuation of an electrical muscle stimulation (EMS) unit, lumbar MEP-X isometric diagnostic testing, and referral to a chronic pain program.

The case was reviewed by Dr. Donald Maudlin on February 8, 2005, and he recommended a short course of multidisciplinary pain management to get the patient off multiple prescription

medications and motivate him back into a more active lifestyle. In reviewing the clinical notes presented for review, this patient has had conservative treatment consisting of extensive physical therapy including a work hardening program, multiple procedures (i.e. multiple pain management injections), and medication management, as well as multiple diagnostic examinations, which have not revealed significant nerve root compromise. The patient presented with subjective complaints out of proportion that one would expect with no other objective evidence. Without documentation on an objective basis, the patient has had a complicated lumbar spine strain. The main purpose of chronic pain programs are to return a patient back to work and also to wean the patient off sedative medications so they can return to some form of vocation. This patient has already been off any kind of opioid medications, and chronic pain program is not medically justified for motivating the patient back into a more active lifestyle. Furthermore, the success rate is reduced dramatically after one year and this injury is approximately three years old. There is no peer review literature to support programs for these types of older injuries. Furthermore, there has been no documentation that the patient has exhausted all surgical procedures for his problem. The chronic pain program at this time has been denied.

Criteria/Guidelines utilized: TWCC rules and regulations.

1. Influence of an outpatient multidisciplinary pain management program on the health related quality of life and physical fitness of chronic pain patients. ISSN 2004, March 17, Volume 3, pages 1477 through 5751. Department of Rheumatology and Institute of Physical Medicine, University Hospital, Zurich, Switzerland.
2. The American College of Occupational and Environmental Medicine Guidelines, Chapter 6.
3. Behavioral Treatment for Chronic Low Back Pain; A systematic review within the framework of the Cochrane, Back Review Group, Spine 2001, February 1; 26(3); pages 270 to 281, editors van Tulder and Ostelo R.
4. Management of Pain, John Bonica, 3rd Edition, 2001.

Physician Reviewers Specialty: Pain Management

Physician Reviewers Qualifications: Texas licensed MD, and is also currently listed on the TWCC ADL list.

CompPartners, Inc. hereby certifies that the reviewing physician or provider has certified that no known conflicts of interest exist between that provider and the injured employee, the injured employee's employer, the injured employee's insurance carrier, the utilization review agent, or any of the treating doctors or insurance carrier health care providers who reviewed the case for the decision before the referral to CompPartners, Inc.

Your Right to Appeal

If you are unhappy with all or part of this decision, you have the right to appeal the decision. The decision of the Independent Review Organization is binding during the appeal process.

If you are disputing the decision (other than a spinal surgery prospective decision), the appeal must be made directly to a district court in Travis County (see Texas Labor Code § 413.031). An appeal to District Court must be filed not later than 30 days after the date on which the decision that is the subject of the appeal is final and appealable. If you are disputing a spinal surgery prospective decision, a request for a hearing must be in writing and it must be received by the Division of Workers' Compensation, Chief Clerk of Proceedings, within ten (10) days of your receipt of this decision.American College of Occupational and Environmental Medicine (ACOEM) Occupational Medical Practice Guidelines, Second Edition

Chapter 6 Pages 113-114

C. Physician Guidelines for Dealing with Potentially Chronic or Chronic Injuries

In general, intervention for treating pain should be time limited and goal oriented. Persons returning to work in six months or less after injury tend to have the best outcomes. Persons who have been out of work for a year or more tend to have poor return to work outcomes. Early detection of potential chronicity also may be an important step in defining early treatment approaches to treating pain or disability because early intervention may increase successful return to work. Clinicians may use several published tools to examine the potential of developing a chronic pain problem (see "Pain Assessment Models and Tools," at the end of this chapter). Properly interpreted, such tools may help identify persons who need more than just interventional pain care and are unlikely to respond to simple pain treatment approaches.

Research suggests that multidisciplinary care is beneficial for most persons with chronic pain, and likely should be considered the treatment of choice for persons who are at risk for, or who have, chronic pain and disability. Flor et al. (1992) conducted a meta analytic review of multidisciplinary pain treatment for chronic back pain, which concluded that chronic pain patients treated in multidisciplinary programs were functioning better than 75% of control patients who either received no treatment or who were treated by conventional unimodal approaches.

Multidisciplinary treatment was found to be superior to conventional physical therapy alone, had benefits that persisted over time, and was beneficial in improving return to work and decreasing use of health care. While the components and approaches of multidisciplinary care often differ, the hallmarks of such programs include:

- Thorough, multidisciplinary assessment of the patient
- The establishment of a time limited treatment plan with clear functional goals
- Frequent assessment of the patient's progress toward meeting such goals
- Modification of the treatment plan as appropriate, based on the patient's progress

Typically, such programs involve ongoing medical care or supervision, exercise or specific physical therapy intervention, psychosocial intervention, and occupational therapy or other services related to daily functioning and/or vocational rehabilitation. Specific multidisciplinary approaches, such as functional restoration, report return to work rates of more than 80% following treatment, with a high percentage of these persons still working after one year. Because not all chronic pain patients may need intensive

multidisciplinary interventions, some programs offer comprehensive multidisciplinary evaluations resulting in specific treatment recommendations for the patient.

American College of Occupational and Environmental Medicine (ACOEM) Occupational Medical Practice Guidelines, Second Edition.
Chapter 6, Chronic pain, Pg 116-117

Summary

Physicians should acknowledge the patient's experience of pain. Pain can be independent of the degree of physical pathology. The pain experience is modified by coping mechanisms; cultural and personal expectations; the patient's current psychological state; tissue damage and repair; and the influences, expectations, and responses of health care providers. It is critical for physicians to convey acceptance of, and empathy with, information the patient shares. Anomalous or exaggerated expressions of pain indicate that medical and psychological evaluations may be warranted.
Pain management focuses on functional restoration. Because return to function is essential to a return to health, occupational health professionals are concerned with return to function. It is very important to identify, at as early a point as possible, the development of chronic pain patterns and responses. Maintaining function will minimize the stiffness, aches, and atrophy that result from being sedentary. Typically, when function improves, so does perceived pain.

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